



PERSONAL HEALTH DECLARATION FORM

KENYATAAN MENURUT SEKSYEN 149(4) AKTA INSURAN, 1996. Anda adalah diminta menerangkan dengan penuh dan benar segala butir-butir yang anda tahu atau harus tahu di atas cadangan Insuran ini, kalau tidak polisi yang dikeluarkan menurut cadangan ini adalah tidak sah.

STATEMENT PURSUANT TO SECTION 149(4) OF THE INSURANCE ACT, 1996. You are to disclose in this Proposal Form, fully and faithfully all the facts which you know or ought to know, otherwise the Policy issued hereunder may be invalidated.

PARTICULARS OF PROPOSER

Name: _____
 Address: _____
 _____ Post Code: _____
 NRIC: _____ Date of Birth: _____
 Occupation: _____ Sex: Male Female
 Tel. (O): _____ (H): _____ Height (cm): _____ Weight (kg): _____

PARTICULARS OF FAMILY TO BE INSURED

	Name	Sex	NRIC	Date of birth
Spouse				
Child 1*				
Child 2*				
Child 3*				
Child 4*				
Child 5*				

* Aged 3 months to 18 years old or 23 years old if full-time student

QUESTIONNAIRE

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Do you or any person to be insured have other medical or hospitalization insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has any application for medical or hospitalization insurance on you or any person to be insured ever been declined, postponed or accepted at other than normal terms? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you or any person to be insured | | |
| i) in the past 5 (five) years been admitted to hospital, undergone or advised to undergo surgery or diagnostic tests (except as a routine check-up)? | <input type="checkbox"/> | <input type="checkbox"/> |
| ii) currently under observation or treatment or taking any medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| iii) suffered or are now suffering from disease of heart, brain, spine, blood vessels, stomach, kidney, liver, lung, ear, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> |
| iv) if female, any disease of the female organs? | <input type="checkbox"/> | <input type="checkbox"/> |
| v) any other illness, disabilities or defects present not already disclosed above? | <input type="checkbox"/> | <input type="checkbox"/> |

If the answer is YES to any of the above, please give details below:

Question No.	Name of Person	Disability	Date treated /Other Details

- | | Yes | No |
|---|--------------------------|--------------------------|
| 4. Do you or any person to be insured reside or intend to reside outside of Malaysia for a period of more than 90 consecutive days? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you or any person to be insured engage in any hazardous sports? | <input type="checkbox"/> | <input type="checkbox"/> |

If the answer is YES to any of the above, please give details below:

Question No.	Name of Person	Details

DECLARATION

I/We hereby declare that the above statement and particulars are true and complete and I/We have not withheld any information that may influence the acceptance of this proposal, and I/We agree that this proposal and declaration shall be the basis of the contract between us and insurance company and I/We agree to accept the Company's policy subject to the terms and conditions contained therein or enclosed therein.

I/We hereby authorize any hospital, surgeon, medical practitioner or clinic or other person who has attended to me/us for any reason to disclose to MUI Continental Insurance Berhad any and all information with respect to any illness or injury and to provide copies of all hospital or medical records/certification, including any earlier medical history. A photostat copy of this authorization shall be considered as effective and valid as the original.

My regular doctor is: _____

Name of clinic: _____ Tel.: _____

Address: _____

*The insurance will not be in force until the proposal has been accepted by the Company.

Date

Signature of Proposer

NOMINATION FORM (in the event of Accidental Death only)

I hereby nominate the following as nominee(s) for this insurance policy and revoke all existing nominees (if any) named earlier.

Name	NRIC/B.C.	Address	Relationship	% of Share

Dated this day of 200.....

Signature of Proposer

Name:
I.C.No.:
Address:

Signature of Witness

Name:
I.C.No.:
Address:

If your intention is for the nominee(s) named herein to receive the policy benefits specifically and not as an executor, then you must assign the benefits of the policy to such person(s)

An assignment would not be necessary if the nominee is a :-

i) spouse ii) child or iii) parent who is being nominated when there is no spouse or child living at the time of making the nomination.

- Note:
1. The witness must be at least 18 years of age and cannot be a named nominee.
 2. A nominee of a Muslim policy owner upon receipt of policy money shall distribute the policy money in accordance with Islamic law